We therefore recommend that patients suffering from acute intermittent porphyria and requiring treatment for chlamydial infection are prescribed doxycycline with the proviso that urinary porphyrin concentrations are measured before and after treatment. This will also allow improvement of the Porphyrin Laboratory Data Bank.

Yours faithfully,
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TO THE EDITOR, *Genitourinary Medicine*

Electron microscopy to differentiate intestinal spirochaetosis from other conditions

Sir,

Intestinal spirochaetosis is present in up to 6·9% of hospital patients undergoing rectal biopsy, and a prevalence of over 30% has been reported in homosexual men.[1] Although its pathological importance is not certain, various clinical symptoms have been ascribed to infestation of the gastrointestinal tract with spirochaetes. These include diarrhoea, rectal discharge, and pain on defaecation. Sigmoidoscopic examination may or may not show normal appearances. The condition is recognised on light microscopy by the presence of a haematoxyphilic band coating the surface of the rectal mucosa. We report a case in which a similar basophilic band was present, but which was not due to spirochaetosis.

A man aged 72 presented with a six week history of diarrhoea that began one week after his return from Spain. He had had no homosexual contact. Physical examination was unremarkable, and sigmoidoscopic appearances were normal. Examination of a rectal biopsy specimen (fig, top) showed normal mucosal architecture and no evidence of inflammation. However, a basophilic band was present at the brush border of the mucosal surface, and the possibility of intestinal spirochaetosis was considered. Transmission electron microscopy of further material from the residual tissue in the paraffin block showed that the cause of the basophilic band was a dense layer of mucus attached to the surface of the brush border, and showed no evidence of

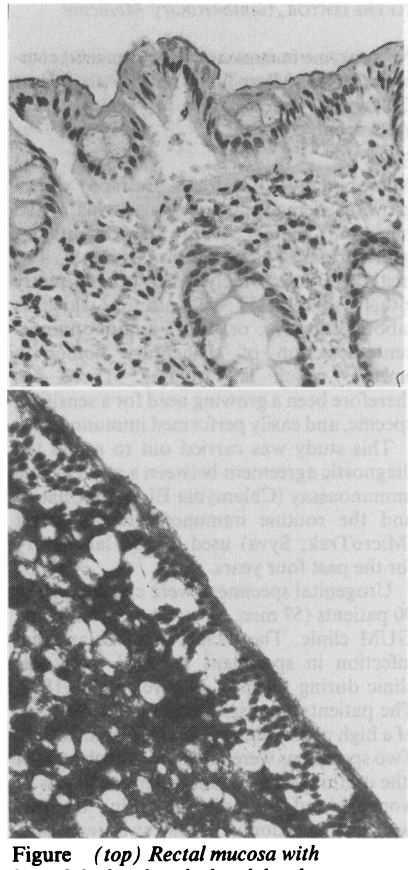

Figure *(top) Rectal mucosa with basophilic band at the brush border, an appearance similar to that seen in intestinal spirochaetosis. Electron micrograph (bottom) of surface of rectal mucosa showing dense layer of mucus on surface of the brush border. Normal numbers of microvilli present beneath mucus layer.*

spirochaetes (fig, bottom). No other organism was identified.

Though the presence of a basophilic band in a rectal mucosal biopsy specimen should alert the pathologist to the possibility of spirochaetosis, this case illustrates the fact that a similar appearance may be produced by other causes. The basophilic band in this case was slightly thinner than that normally associated with spirochaetosis, and individual spirochaetes could not be shown convincingly using the 100 x objective. Though these subtle differences may help in diagnosis, electron microscopy remains the final arbiter.

Yours faithfully,
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Reference

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TO THE EDITOR, *Genitourinary Medicine*

Trichomonal vaginitis refractory to conventional treatment

Sir,

Recent reports in *Genitourinary Medicine*[1–3] have highlighted the difficulties in managing trichomonal vaginitis when conventional treatment with metronidazole has failed. There is a place for more aggressive treatment than suggested.

Metronidazole is well absorbed in the absence of gastrointestinal diseases and should be given by mouth rather than intravenously unless the patient is vomiting. It can safely be given by mouth in doses of up to 3 g a day for 14 days, but doses exceeding 4 g a day for 14 days have produced peripheral neuropathy, which may be prolonged and disabling.[4]

Two women seen recently have been cured only by high dose treatment. One, who had been given 17 different courses of treatment during two and half years without success, responded to oral metronidazole 3 g a day by mouth in divided doses and 1 g vaginally at night for 18 days. The second, similar, patient was cured by the same regimen, but for 14 days.

Two points seem worthy of emphasis. Firstly, the difficulty that many of us have in getting sensitivity tests performed on trichomonads that appear clinically to be resistant to metronidazole. Facilities for sensitivity testing using an acceptable standard method need to be made more easily available.[5] Secondly, vaccination has proved useful in the prophylaxis of recurrent trichomoniasis, although not in treating resistant organisms. In discussing its mode of action we should eschew references to "aberrant" and "different" strains of *Lactobacillus acidophilus*.[6] Such terms do not accord with modern microbiological concepts.[7]

Yours faithfully,
S A Seligman